

# Updated Overview of Prospective Outpatient Hospital Payment Methodology

#### Sara Harper and EP&P Consulting October 19, 2004



- □ Recap of Timeline/Proposed Timeline
- □ Recap of Methodology
- ☐ Hospital Feedback
- □ Changes to Methodology
- □ Data Updates
- ☐ Examples of How Procedures Will Be Priced (separate handout)



- □ Feb/March '04– AHCCCS draft proposed rates
- ☐ March/April Individual hospital meetings
- □ May Senate Bill 1410 passes
- □ July 1 "Interim methodology" implemented
- □ October 1 CCR updates as mandated
- □ April October '04 AHCCCS updates draft rates



- □ October 2004 Review updated rates
- □ Nov/Dec Individual hospital meetings
- □ Jan/Feb Finalize rates
- □ July 1, 2005 Implement new rates



## Recap of Methodology

- □ AHCCCS developed an outpatient hospital fee schedule with major features similar to the Medicare:
  - Grouping procedures into Ambulatory Payment Classifications (APCs) for ratesetting purposes
  - Grouping items that bundle with surgery and ED claims for pricing purposes



- □ Data used to set fees was Arizona hospital-specific Medicare Cost Report and claim/encounter data.
- □ Each AZ cost-based fee derived was compared to the comparable Medicare fee and AHCCCS nonhospital capped fee schedule.
- □ If there was not sufficient cost data from AZ hospitals for a given procedure (that is, less than 20 observations statewide), then the Medicare fee for the procedure was used.



#### Steps:

- 1. Define the dataset used to set the fees on.
  - Claims/encounters matching cost report years
- 2. Define the hospitals included in this dataset.
  - All non-IHS hospitals that had a cost report and AHCCCS outpatient hospital utilization.
- 3. Cost out the charges using revenue code CCRs.
  - Cost and charge data from Medicare Cost Reports
- 4. Inflate costed claims to midpoint of rate year.



- 5. Bundle details with surgery and ED procedures.
  - Using the list of revenue codes from Medicare 2004 rule
- 6. Group procedures into APCs where applicable.
  - Using grouping methodology from Medicare 2004 rule
- 7. Calculate median cost at procedure code level (for laboratory) or APC level (all others).
- 8. Multiply each median cost by 105%.
- 9. Compare fee in Step #8 against comparable fee in Medicare. Select the higher of the two.
  - The "greater of" logic has been capped (see slide #9)



- □ Proposed rates do not pay same as current CCR methodology.
- □ Proposed rates not provided for specific procedures (chemotherapy, radiation therapy, cardiology, PT, OT, ST, audiology, etc.)
- □ Proposed emergency room rates did not cover costs for high end trauma cases.





- ☐ Hospital feedback
- □ CMS approval concerns
- □ Updated to reflect more recent data

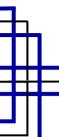


#### Multiple Surgery Payment

□ For claims with multiple surgeries, AHCCCS will pay the 1<sup>st</sup> surgery at 100% of the set fee, and the the 2<sup>nd</sup> surgery at 50% of the set fee (similar to Medicare). (Note: there are exceptions for those procedures that are intended to be paid 100/100).



- ☐ The "greater of" AZ hospital cost-based fee or Medicare fee may be capped when the Medicare fee is higher:
  - If the Medicare fee is higher, the Medicare fee will be used as long as the Medicare fee is not greater than 125% of the comparable AZ hospital-based fee. When the Medicare fee is more than 125% higher, the capped fee will be equal to the AZ hospital cost-based fee \* 125%.
  - If the AZ hospital cost-based fee is higher, this cap will not apply.



# **Methodology Changes**

- □ Peer groups and rate adjustments:
  - Large rural (100+ beds): Peer group adjuster = 20%
  - Small rural (0-99 beds): Peer group adjuster = 30%
  - Critical access hospitals: Peer group adjuster = 40%
  - Public: Peer group adjuster = 20%
  - Freestanding Children's: Peer group adjuster = 20%
  - Level I Trauma centers: Peer group adjuster of 20% applied to Level 2 and Level 3 ED claims only



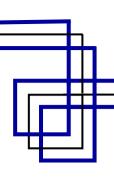
- □ Updated fee schedule is based on FYE 2002 Medicare Cost Report data; March-based draft fee schedule was based on FYE 2001 data.
- □ Obtained more recent/more complete FFY2003 claim/encounter data from the system.
- □ FFY 2003 dataset includes more complete representation of all claims/encounters, including those with charges >\$40,000, and multiple day claims, neither of which were priced, but defaulted to the statewide CCR in March.

## **Data Updates**

- ☐ Many procedures (primarily alpha codes) were assigned rates based on the AHCCCS Physician Fee Schedule effective 5/1/04 (these procedures defaulted to statewide CCR in March-based draft fee schedule).
- □ Statewide default CCR based on FYE 2002 Medicare Cost Report data is .2957 (vs. .3175 using FYE 2001 data). AHCCCS still estimates that approx. 2-3% of total outpatient charges will be paid based on the statewide default CCR.



- □ The most prevalent procedures (based on charge volume) that appear in the dataset that are paid using the statewide default CCR include:
  - **–** 33249 36000 36200 36245 36246 36489 36533
  - **-** 36535 36600 51600 51701 51702 53670 59050
  - 61793 62290 69990 76001 76003 76005 76085
  - **–** 78890 94665 94760 94761 94762 97601 99234
  - A4641 A4646 A4647 J2000
  - These procedures are estimated to comprise 2/3 of the total charges in the 2-3% estimated to be paid CCR.



### **How Procedures Will Be Priced**

☐ See specific examples on separate handout